

**AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION
ABOUT ALCOHOL OR DRUG TREATMENT INFORMATION TO THE
DEPARTMENT OF HUMAN SERVICES AND THE CONTRACTED
CHEMICAL DEPENDENCY FACILITIES**

I, _____, authorize
(Name of Patient)

The following alcohol or drug treatment program: _____
(Name and address of
the treatment program authorized to make a request for funding for me to
receive chemical dependency treatment.)

communicate with The South Dakota Department of Human Services and disclose one or more of the following information: (Mark those that apply)

- ☐ My name and other personal identifying information;
- ☐ My status as a patient in (alcohol and/or drug) treatment;
- ☐ Financial Information;
- ☐ Diagnosis and treatment recommendations;
- ☐ Summary of treatment plan, progress and compliance;
- ☐ Continued stay criteria and requests;
- ☐ Discharge summaries;
- ☐ Treatment Needs Assessment;
- ☐ Other: _____

The purpose of the disclosures authorized in this consent is to make decisions regarding my placement in a financially supported treatment program and/or to permit the appropriate contract administration activities.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as follows:

One Year after this authorization form is signed.

I understand that generally _____ may not condition
(Name of program)
my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Dated: _____
Signature of patient

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42CFR 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

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